DOCUMENT RESUME

ED 428 476 EC 307 079

AUTHOR Thomson, Linda Kohlman; Lieberman, Deborah; Murphy, Roberta; Wendt, Eugene; Poole, Janet; Hertfelder, Sarah D.

TITLE Developing, Maintaining, and Updating Competency in Occupational Therapy: A Guide to Self-Appraisal.

INSTITUTION American Occupational Therapy Association, Rockville, MD.
PUB DATE 1995-00-00
NOTE 55p.
AVAILABLE FROM American Occupational Therapy Association, Inc., 4720 Montgomery Lane, P.O. Box 31220, Bethesda, MD 20824-1220; Tel: 301-652-AOTA (2682); TDD: 800-377-8555; Fax: 301-652-7711.
PUB TYPE Guides - Non-Classroom (055)
EDRS PRICE EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Check Lists; *Competence; *Disabilities; *Occupational Therapy; Professional Continuing Education; *Professional Development; *Self Evaluation (Individuals); *Therapists

ABSTRACT

This guide is intended to help occupational therapists maintain and update their professional competency through use of a self-appraisal competency checklist. The first section discusses issues related to competence such as the demands of new situations or client populations and the essentially self-directed nature of the lifelong process of maintaining professional competence. The following section considers the importance of collaboration in maintaining individual competence including national associations, special interest groups, certification and regulatory agencies, and licensure/regulatory boards of practice. Thirteen specific methods for achieving competency are listed such as independent study, academic coursework, peer review, and on-the-job training. Also described are 10 commonly used measures to document competency in occupational therapy including written examinations, self-appraisal tools, and evaluation by clients/employees. The self-appraisal checklist involves five charts which provide: (1) an assessment and intervention checklist; (2) a practitioner competency checklist; (3) a work and behavior checklist; (4) maintaining and updating a clinical competency checklist; and (5) a professional development plan. Appended are three typical vignettes. (Contains 51 references.) (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 428 476

Developing, Maintaining, and Updating Competency in Occupational Therapy: A Guide to Self-Appraisal

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
✓ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.
PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY
Andrews
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
2B

by
The Competency Task Force

Linda Kohlman Thomson, MOT, OT(C), FAOTA—Chairperson
Deborah Lieberman, MHSA, OTR/L, FAOTA
Roberta Murphy, BPA, COTA, ROH
Eugene Wendt, PhD, OTR
Janet Poole, PhD, OTR, FAOTA
Sarah D. Hertfelder, MEd, MOT, OTR, FAOTA—Staff Liaison

for
The Commission on Practice

Jim Hinojosa, PhD, OTR, FAOTA—Chairperson

The American Occupational Therapy Association, Inc.

AOTA

BEST COPY AVAILABLE

EC 307 079

DEVELOPING, MAINTAINING, AND UPDATING COMPETENCY IN OCCUPATIONAL THERAPY:

A GUIDE TO SELF-APPRAISAL

The American Occupational Therapy Association, Inc.
Bethesda, Maryland 20824-1220

by

Competency Task Force:
Linda Kohlman Thomson, MOT, OTR, OT(C), FAOTA - Chairperson
Deborah Lieberman, MHSA, OTR/L, FAOTA
Roberta Murphy, BPA, COTA, ROH
Eugene Wendt, PhD, OTR
Janet Poole, MA, OTR, FAOTA
Sarah D. Hertfelder, MEd, MOT, OTR - Staff Liaison

for

The Commission on Practice
Jim Hinojosa, PhD, OTR, FAOTA, Chairperson

Copyright © 1995 by The American Occupational Therapy Association, Inc.
All rights reserved.

Developing, Maintaining, and Updating Competency in Occupational Therapy: A Guide to Self-Appraisal may not be reproduced in whole or in part, by any means, without permission. For information, address: The American Occupational Therapy Association, Inc., 4720 Montgomery Lane, P.O. Box 31220, Bethesda, MD 20824-1220.

Disclaimers

"This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold or distributed with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought."
—From the Declaration of Principles jointly adopted by the American Bar Association and a Committee of Publishers and Associations.

It is the objective of the American Occupational Therapy Association to be a forum for free expression and interchange of ideas. The opinions and positions expressed by the contributors to this work are their own and not necessarily those of either the editors or the American Occupational Therapy Association.

Printed in the United States of America

TABLE OF CONTENTS

Issues Related to Competency and Occupational Therapy 1

Maintaining Competence - A Collaborative Effort 4
- Individuals and Organizations 5
- National Associations 5
- Special Interest Sections (SISs) and State Occupational Therapy Associations 6
- Certification and Regulatory Agencies 6
- Licensure/Regulatory Boards of Practice 6

Methods to Achieve Competency 6

Measures to Document Competency 8

Table 1 - Methods of Achieving Competency and the Corresponding Measures of Competency 9

Table 2 - Arenas and Commonly Accepted Measures to Document Competency 10

Self-Appraisal Competency Checklist for Occupational Therapy Practitioners 15
- Instructions 15

Chart I - Practitioner Competency - Assessment and Intervention Checklist 18

Chart II - Practitioner Competency Checklist 26

Chart III - Work and Behavior Competency Checklist 27

Chart IV - Maintaining and Updating Clinical Competency Checklist 28

Chart V - Professional Development Plan 30

Appendix 31

References 33

Bibliography 36

DEVELOPING, MAINTAINING, AND UPDATING COMPETENCY IN OCCUPATIONAL THERAPY:

A GUIDE TO SELF-APPRAISAL

Issues Related to Competency and Occupational Therapy

Establishing, maintaining, and measuring competency is essential for the survival of the profession of occupational therapy in today's health care and education systems. It is imperative to look beyond entry-level competency and focus on the broader mission of continuing competence over time. Competency is an inherent component of any profession, but no profession has been able to define and measure competency cost-effectively or in a manner that ensures competence beyond a single point in time.

The American Occupational Therapy Association (AOTA) has promoted the competency of occupational therapy practitioners through the creation and administration of certification examinations from 1939 to 1987. In 1988, The American Occupational Therapy Certification Board (AOTCB) was incorporated. The AOTCB continued the entry-level certification program and began a disciplinary action program to include all OTRs and COTAs (not just members of The American Occupational Therapy Association). The AOTA also established a code of ethics, adopted a policy on competency, and developed standards of practice. In 1991, the Representative Assembly charged the Commission on Practice (COP) to develop a document about competency issues relating to the use of physical agent modalities. The COP decided that it was important for the profession of occupational therapy to examine competency issues beyond those relating only to physical agent modalities and established a Competency Task Force to address the issue. The profession has an obligation to address competency in practice on a much broader scale and to address competency issues at all levels and in all settings of practice. Therefore, the COP directed the Competency Task Force to address the issue of competency as it applies to all aspects of occupational therapy practice.

Competency is addressed in the *Occupational Therapy Code of Ethics* document. It states, "Occupational therapy personnel shall achieve and continually maintain high standards of professional competence" (AOTA, 1994a). This principle identifies the following activities as being necessary to maintain the professional competence of occupational therapy personnel:

1. Holding appropriate credentials,
2. Conforming to the standards of practice of the AOTA,
3. Participating in professional development and educational activities,
4. Performing duties with accurate and current information,
5. Protecting service recipients by ensuring duties assumed by or assigned to other occupational therapy personnel are commensurate with their qualifications and experience,
6. Providing appropriate supervision, and
7. Referring to or consulting with other service providers when additional knowledge and expertise are required.

These activities demonstrate that competence must be achieved by many avenues and that each practitioner must be responsible and actively involved in maintaining and updating knowledge and skills.

Competency is an active process in which individuals must have an investment in maintaining and increasing their level of expertise. A report to the 1992 Representative Assembly by Hinojosa and Hansen in *Advanced Practice Review* stated that competency and the desire to improve one's skills for occupational therapy practitioners come from living the daily life as a practitioner over a number of years. Day-to-day experiences are powerful motivators for practitioners to maintain and update their competence.

Practice in any profession requires the processing of technical and scientific knowledge for use in a context that is rapidly changing and uncertain. The ability to think about what one does and why--assessing past actions, current situations, and intended outcomes--is vital to intelligent practice that is reflective rather than routine or reflexive. Reflection also influences how one grows as a professional by influencing how successfully one is able to learn from one's experiences (Richert, 1988).

As professions grow and change and the roles and responsibilities of practitioners change, an expanded body of knowledge and skill becomes necessary to maintain competence. The process of updating one's skills, and not just maintaining, becomes necessary to remain competent within a profession.

Maintaining professional competence is a lifelong process that is mostly self-directed and internally driven. Professional competence is facilitated by an individual's attitude, value system, and overall level of motivation. Motivational factors encourage individuals to remain current with changing practice. Factors such as the feeling of accomplishment, challenging work, the opportunity to be creative, the opportunity to exercise initiative, desire for excellence, and assuming responsibility were identified as important components in motivating people to maintain job competence (Farr & Dubin, 1980). Incentives for change

may be internally motivated, such as the desire to perform quality work, or externally driven because of regulations such as licensure laws.

Competency changes with the demands of each new situation. A practitioner may feel very competent in the day-to-day demands of the job, but then is confronted with a new demand for which he or she is not as competent. The dynamic nature of competency is also experienced whenever a practitioner changes jobs. No matter how similar the new job is to the old one, the competence of the individual is affected by the new demands, even if only for a short period of time. Competence is reflected by job performance and is assessed by how skillfully an individual performs in a particular work environment. Phillips (1991) described competence as having the qualifications or potential to perform in an appropriate manner and having the ability to make judgments about one's own performance.

Understanding that competency rests with the individual and the specific job demands is particularly important when comparing the competence of a certified occupational therapy assistant and a registered occupational therapist. One is not more or less competent because of a hierarchy in job positions, because competency relates to the individual's ability to perform the required job duties. The competence of a certified occupational therapy assistant is not determined by comparing the person's knowledge and skills to the roles and job demands of a registered occupational therapist. Because competency is based on specific knowledge and skills, it is possible within the same department for a certified occupational therapy assistant with 1 year of experience to demonstrate a higher level of competency in a particular skill than a registered occupational therapist with more experience.

Levels of competence also vary depending on the setting, role demands, client populations, and other variables. Within an individual, there are many varying levels of competence, depending on what components of therapeutic knowledge and skill are being considered. One may be highly competent in fabricating a dynamic splint, but less competent in completing a developmental assessment of an infant. Willis and Dubin (1990b) stated, "No professional is ever completely obsolete or totally up to date" (p.4). There are always areas of greater or lesser competence within an individual. It is also known that if both the knowledge and performance components of a therapeutic skill are not practiced, competency declines over time. For example, if a person who is competent in designing environmental control systems and instructing clients in their use does not do this for several years, competency in performing this skill will decline. Competency could be regained by methods such as study of new technology, clinical experience, and continuing education courses.

Wilson (1977) stated, "Competencies are defined as those performance, knowledge, and skill abilities requisite for fulfilling the responsibilities of the given practitioner's generic position" (p.574). Individuals must be proficient in their knowledge base, their performance abilities, and their ability to analyze and solve issues encountered in their practice or in the profession.

An individual may be a highly skilled technician, but not have the theoretical knowledge necessary to make expert clinical decisions. Similarly, an individual may have high levels of knowledge, but not have the clinical skills to apply the knowledge in a therapy setting. One of the most challenging aspects of determining competency is that many of the measures of competence used throughout the health care professions rely solely on assessments of knowledge without the accompanying assessment of the ability to perform the necessary skills. Competency is not fully determined unless some form of performance is demonstrated. It is much easier to assess one's knowledge base than it is to assess one's performance. When measures of performance are considered, the time and cost factors to enact them are usually prohibitive. No profession has solved this dilemma, but many professional organizations, such as the AOTA, are trying to address it.

Maintaining and updating one's skills is a developmental and ongoing process throughout one's career. There are a variety of methods to achieve competency, and many measures of competency are used to document one's knowledge and performance skills. Ensuring competence is the responsibility of everyone, including the individual practitioner, employers, professional associations, and regulatory boards. The key, however, rests with the individual who must be self-directed to attain and maintain competence.

Maintaining Competence - A Collaborative Effort

Maintaining professional competence is described as a lifelong process that is ongoing throughout one's career. For professionals to keep up to date, they must make use of theories, points of view, techniques, and practices that are in the forefront of their field and allied or adjacent fields. It requires a systematic approach, not just the occasional reading of a journal or book, to keep up to date (Dubin, 1990).

There are many factors and variables involved in the maintenance of professional competence. Mostly, it is self-directed, meaning individuals engage in self-assessment of their current level of competence and then determine what needs to be enhanced and the method to gain such knowledge or skill (Willis & Tosti-Vasey, 1990). However, it has been suggested that the assessment of competence and in turn the maintenance and improvement or updating of professional competence can be viewed as a team approach involving professional associations, regulatory agencies, individual practitioners, work settings, educational programs, etc. (Willis & Dubin, 1990a). Each of these entities has a major role to play relative to ensuring the competence of individuals within the profession.

Individuals and Organizations

Organizations need to be aware of factors within the work setting that foster competence in its members. Opportunities need to be provided and continuing education and career development encouraged to stimulate professional competency (Kaufman, 1990). Time should be allocated for hands-on supervision, training, and development of professional goals and development plans.

Although many place the responsibility of creating a climate that motivates professional development on the organization and management, ultimately it is the individual who must be aware of the need for continuing professional education and who must exercise individual responsibility to maintain and update competency. Individuals and organizations can work in concert to create environments that promote competency.

Maintaining and updating competence is a dynamic and collaborative process. As stated previously, it involves broad commitment and the combined efforts of national associations, regulatory agencies, employers, and the individual practitioner. The roles and responsibilities overlap, but each has a part in ensuring that occupational therapy practitioners are competent in their profession.

National Associations

National health professional associations need to play an integral part in contributing to the entry-level and ongoing competence of their members (Gray, 1977; Wilson, 1977). The establishment of standards of practice, a code of ethics, educational essentials, and association documents form the basis of ensuring competency.

AOTA takes an active role in the development of entry-level competency education programs, post-professional graduate programs, and continuing education programs. The Commissions on Practice, Standards and Ethics, and Education all contribute to promoting and establishing competency in the AOTA membership. The national Association forms cooperative efforts with academic institutions and state and regional groups to provide continuing education programs and to share information regarding practitioner needs. The AOTA sets the tone on a national basis by encouraging and motivating practitioners to maintain ongoing competence (Wilson, 1977).

Special Interest Sections (SISs) and State Occupational Therapy Associations

In partnership with the AOTA, national and state SISs and state associations provide networks to keep the profession aware of advances and changes in practice. These professional groups play an integral part in developing and delivering continuing education opportunities for practitioners to maintain and update competency. They also promote the establishment and maintenance of regulatory laws that assist in determining the competency of occupational therapy practitioners.

Certification and Regulatory Agencies

The AOTCB is a nonprofit, nongovernmental certification agency formed in 1987 whose primary mission is to serve and protect the public interest and welfare by establishing high standards for certification, developing valid and reliable certification examinations, and by investigating and taking disciplinary action against individuals who are either unethical, impaired, or incompetent. "The certification examinations, which are based on an entry-level job analysis study, serve as an objective measure of the knowledge and skills required of entry-level COTAs and OTRs" (AOTCB, 1991). Although there is no formal mechanism to ensure continued competence, AOTCB's Disciplinary Action Committee has the power to investigate complaints of individuals whose behavior reflects incompetence, a breach of ethics, or impairment.

Licensure/Regulatory Boards of Practice

In most states, boards regulate the practice of occupational therapy. The purpose of such boards is to protect the public and the consumer by ensuring that the professional provider has met certain criteria indicating a basic or entry-level measure of competence. It is also the role of regulatory boards to ensure that practitioners continue to remain competent. Each state regulatory board must develop mechanisms to assess continued competency. For some, this is done by occupational therapy practitioners fulfilling continuing competency requirements established by the board. It is the role of the regulatory board to make sure that regulations reflect current practice.

Methods to Achieve Competency

There are a variety of methods to achieve, maintain, and update competency. Each practitioner uses a combination and pattern of methods unique to him or her. It is important not to rely solely on one method to attain competency, because each method has certain advantages and limitations. Combining methods in the career-long process of maintaining

and updating competency allows practitioners to have greater opportunities to ensure competency. Listed below are the most commonly used methods to achieve competency in occupational therapy.

1. **Independent Study**
   Engaging in self-directed learning, frequently focused on one topic; includes individual or group activities such as reading or discussing journal articles, books, and videotapes.
2. **Academic Coursework**
   Attending university, college, or vocational/technical course(s) which may or may not be part of a degree program.

3. **Continuing Education**
   Attending workshops, seminars, and inservices, and completing self-study courses.

4. **Teaching Activities**
   Studying, organizing information, and teaching a specific topic for academic, continuing education, or community education courses.

5. **Presentations**
   Studying, organizing information, and teaching a specific topic for conference programs, workshops, poster sessions, or inservices.

6. **Publications**
   Studying, organizing, and writing on a specific topic for newsletters, journals, books, or newspapers.

7. **Research Activities**
   Designing, implementing, and completing research projects and grants as an individual or as part of a team.

8. **Professional Certification**
   Completing defined academic requirements from an accredited school, completing the knowledge and performance requirements of fieldwork, and passing a written, knowledge-based examination for entry into a profession.

9. **Specialty Certification**
   Completing defined requirements (usually consisting of years of experience, professional activities, and contact hours in a specific area), and passing an examination testing knowledge or performance.

10. **Recertification**
    Completing defined requirements such as years of experience or contact hours, professional activities; and may involve passing a written examination.

11. **Preceptor/Supervisor/Mentor Relationship**
Imparting of knowledge and skill from one individual to another in a one-to-one relationship.

12. **Peer Review**
Assessing the performance of an individual by a peer or peers, and may include activities such as observation, case study review, and chart audit.

13. **On-the-Job Training and Experience**
Gaining knowledge and performance skills through daily practice; may include internships.

Measures to Document Competency

Documenting competency is a difficult and challenging task. Segments or components of an individual's competency can be measured, but competency in its entirety has not been effectively measured. Professions use a variety of measures in attempting to document competency. These measures vary depending on the method used to achieve competency (see Table 1). Each measure has its limitations. For instance, some document only knowledge rather than actual performance.

The most common arenas that demand documentation of competency are legal, educational, regulatory, reimbursement, and practice. Each arena has commonly accepted measures of competency (see Table 2). All of the arenas affect each practitioner and agency, but vary according to the type of population served, type of facility, reimbursement source, and geographical location. Using a combination of measures to document competency gives the best indicator to date.

TABLE 1

METHODS OF ACHIEVING COMPETENCY AND THE CORRESPONDING MEASURES OF COMPETENCY

Methods Commonly Used to Achieve Competency	Measures Commonly Used to Document Competency
1. Independent Study	Written examinations Continuing education credits or contact hours
2. Academic Coursework	Written examinations Academic degree Course credits Grade-point average
3. Continuing Education	Continuing education credits or contact hours Academic course credits Written or performance examinations
4. Teaching Activities	Evaluations by students and participants
5. Presentations	Evaluations by participants Number presented Type of publication Selection process
6. Publications	Number authored Type of publication Selection process First, second, etc., author
7. Research Activities	Grant funding Primary, secondary, etc., investigator
8. Professional Certification	Documentation of meeting eligibility requirements for taking exam Written examination
9. Specialty Certification	Years of experience or direct treatment hours Written examination
10. Recertification/ Relicensure	Continuing education credits or contact hours Years of experience or direct treatment hours Written examinations
11. Preceptor/Supervisor/ Mentor Relationship	Evaluations by students and employees
12. Peer Review	Competency checklists or rating forms Awards and honors Quality management activities
13. On-the-Job Training and Experience	Years of experience Competency checklists or rating forms Self-appraisal tools Quality management activities

TABLE 2

ARENAS AND COMMONLY ACCEPTED MEASURES TO DOCUMENT COMPETENCY

Arenas	Commonly Accepted Measures to Document Competency
Legal	Written examinations Competency checklists or rating forms Continuing education credits or contact hours Years of experience or direct treatment hours Presentations and publications Academic degree Awards and honors
Educational	Written examinations Self-appraisal tools Competency checklists or rating forms Evaluation by students/participants/employees Continuing education credits or contact hours Presentations and publications Academic degree Awards and honors
Regulatory	Written examinations Competency checklists or rating forms Continuing education credits or contact hours Years of experience or direct treatment hours Presentations and publications Academic degree Quality management activities
Reimbursement	Written examinations Academic degree Quality management activities
Practice	Written examinations Self-appraisal tools Competency checklists or rating forms Evaluation by clients/participants/employees Years of experience or direct treatment hours Presentations and publications Academic degree Quality management activities

The following list describes the most commonly used measures to document competency in occupational therapy and their limitations.

1. Written Examinations

Written examinations are used for entry-level certification, recertification, and some specialty certifications. They are also used to determine competency in academic coursework and some continuing education courses. Passing a written examination is credible proof of competency in the legal, educational, regulatory, practice, and reimbursement arenas.

Written examinations measure an individual's knowledge base. However, they may not test clinical reasoning and complex issues involving judgment and are indirect indicators of what individuals will do in real life (Kane, 1992; Pottinger, 1979). The issue of using multiple choice questions to test clinical reasoning or complex situations involving judgment is controversial. Multiple choice examinations measure the ability to recognize rather than recall, which is another limitation. A disadvantage of using written examinations for recertification is that they do not conform to the dynamic nature of most professions (Pottinger). For practice concerns, Klemp (1977) says that the amount of knowledge measured by a test is unrelated to performance.

2. Self-Appraisal Tools

Saylor in 1990 identified personal reflection as a way of reviewing one's repertoire of clinical experience and competency. Reflection provides the time and opportunity for appropriate self-appraisal necessary to attain and maintain high professional standards. Self-appraisals can be used to measure competency in job performance in several ways. In one way, individuals compare their perceived knowledge and performance to prescribed criteria. Examples of this method are competency checklists and career ladders (Guerrero & Hansen, 1993), and Occupational Therapy Roles (AOTA, 1993). Other methods are to rate oneself on the knowledge of a subject matter (Bailey, Buysse, & Palsha, 1990; Cottrell, 1990; Humphry & Geissinger, 1992; Weerakoon & Fernando, 1991) or even rate one's videotaped performance (Mir, Evans, Marshall, Newcombe, & Hayes, 1989). Individuals can also engage in self-assessment of their current level of professional performance to determine what level of knowledge and performance proficiency is necessary and how to improve needed knowledge and skills. Self-appraisals are used mostly in the practice and educational arenas.

Self-appraisals are based on the assumption that individuals are capable of honestly and accurately rating themselves. Some research has shown that there is a relationship between an individual's actual performance and a self-assessment of that ability (Malone Beach E.,

1987). However, one study showed that individuals tend to overestimate their abilities unless the ratings are compared to some objective performance measure (Mabe & West, 1982).

3. Competency Checklists or Rating Forms

These are used to measure competencies in clinical skills by the direct observation of performance (Carline, Wenrich, & Ramsey, 1989; Hays, 1990; Inman & Haugen, 1991; Mir et al., 1989) or by auditing charts. Checklists may be completed by a supervisor, peers, or trained raters. They are used to provide evidence of competency in the legal, regulatory, and practice arenas (Kremer, 1991; Mir et al.).

Competency checklists or rating forms need to be as objective and reliable as possible, so they must be carefully constructed. The use of these is gaining in popularity in clinical practice.

4. Evaluation by Clients/Students/Participants/Employees

Evaluations completed by clients, students, participants, and employees may be used to evaluate a professional's performance. These measures are typically used in academic courses, formal presentations, and continuing education courses as indicators of the presenter's mastery of the subject matter and teaching skills. Evaluations by clients are used to assess competency in practice, evaluations by students are used to assess the competency of a therapist as a fieldwork educator in the clinical setting, and evaluations by employees may be used to assess a supervisor's or manager's competency.

These evaluations tend to be very subjective, with objectivity being difficult to achieve. A disadvantage of these evaluations is that clients and students usually make judgments by whether they were treated fairly. The evaluator's feelings about the person may color the ratings and create inaccurate rating of the evaluated person's competency (Carline et al., 1989).

5. Continuing Education Credits or Contact Hours

This measure involves keeping track of the credits or contact hours completed by attending continuing education courses. Many states require a certain number of credits or contact hours for relicensure. Frequently, state regulatory boards also have specifications that the courses must meet, such as to gain prior approval or have specified objectives. This is also true for some recertification processes, such as in hand therapy and pediatric therapy where continuing education is one of a number of options for establishing recertification. This

measure is accepted to demonstrate competency in the legal, education, regulatory, and practice arenas.

An assumption is made that participating in continuing education courses maintains or improves competency. As discussed earlier, most continuing education courses are knowledge based without any evaluation at completion to determine if knowledge was actually gained. Literature has documented that continuing education is not related to improvement in practice (Mandelbaum, 1987; Mays, 1986; Page, VanWart, Raudzus, & Kettyls, 1979; Poole, 1989). Despite this weakness, participation in continuing education courses as a regulatory requirement is believed by many to be better than having no requirements. Regulatory boards continue to struggle with the difficulty of measuring ongoing competency in a cost-effective and equitable manner.

6. Years of Experience or Direct Treatment Hours

Eligibility for specialty certification for pediatric and hand therapy is in part based on the number of years in practice and the number of direct hours in treatment with a specific population. This measure is commonly used in the legal, practice, and regulatory arenas to establish competency.

This measure assumes the more experience a person has or the more hours an individual has worked, the more competent he or she is. Unfortunately, this assumption does not always hold true. It is also difficult to identify the learning plateau that occurs over time and how competency is affected by this phenomenon.

7. Presentations and Publications

Many professionals maintain updated lists of presentations they have given and publications they have written. A degree of competency is usually attached to the number given, where the person presented (local, national, invited speaker, etc.), and if the selection process was peer reviewed. For publications, the level of competency is usually associated with the number written, type of publication (newsletter, journal, book, etc.), if the selection process was peer reviewed, and if the individual was the first author or not. These measures are used in the educational, practice, regulatory, and legal arenas.

The assumptions behind these measures of competency are that one is asked or chosen to present because of expertise in an area or that one is knowledgeable enough about a subject to write about it. Presentations and publications also document competency more in terms of knowledge base than in performance abilities.

8. Academic Degree

In our culture, it is commonly accepted that an academic degree measures competency in a particular area. There are usually defined criteria an individual must meet in order to enter a course of study. In order to receive most academic degrees, an individual must complete a curriculum of study that has been accredited by an agency outside the degree- granting institution. Course credits and grade point averages are used as measures of competency during academic coursework. Academic degrees are used in the legal, education, practice, regulatory, and reimbursement arenas.

A limitation of this measure is the inconsistency found among educational programs offering the same academic degrees. Importance is placed on receiving the academic degree, with very little emphasis placed on the actual mastery or competency achieved in the process. One individual may complete a degree process and achieve a high level of competency, while another person in the same degree process will barely meet the minimum requirements. In entry-level practice, these two individuals are initially viewed as being equally competent.

9. Awards and Honors

Recognition by peers in the form of an award or honor is a measure of competency. The degree of competency associated with an award or honor is usually correlated with the body bestowing the award or honor (i.e., employer, state association, national association) and the criteria for being selected. This measure is used mostly in the legal and education arenas.

One limitation of awards and honors as measures of competence is that some selection processes may be too subjective. Another problem is they frequently are given for volunteer contributions to a foundation, association, or agency, and may not correlate to competency in clinical practice.

10. Quality Management Activities

Quality management activities are used to document the effectiveness and efficiency of health care services and may be considered as a measure of competency. Functional outcome studies are one example of a quality management activity that determines an individual's or service's level of competency. Monitors are also used to document the quality of the services provided and, indirectly, the competency of the care provider. These activities are measures of performance and are used in the regulatory, reimbursement, and practice arenas.

A limitation of these activities is they are frequently a measure of a total program's effectiveness versus an individual's performance. Data are usually aggregate in nature and, therefore, it is difficult to determine an individual's level of competency.

Self-Appraisal Competency Checklist for Occupational Therapy Practitioners

The attached self-appraisal tool is a method for individuals to appraise their own skill and competency level.

There are five charts to be completed. These include:

Chart I - Practitioner Competency Items - Assessment and Intervention Checklist
Chart II - Practitioner Competency Checklist
Chart III - Work and Behavior Competency Checklist
Chart IV - Maintaining and Updating Clinical Competency Checklist
Chart V - Professional Development Plan

Instructions

This Self-Appraisal Competency Checklist is a thorough self-appraisal tool designed to assist in determining levels of competency in practice. Allow time to complete it and use several sessions to reflect on your knowledge and performance skills. The process of personal reflection is important to gain the most from the self-appraisal.

Be honest with yourself. Check yourself to ensure that you are not consistently rating yourself too high or too low. Be comfortable with your rating decisions. If you are consistently rating yourself in one category, then you are probably not discriminating enough among your skills. No one person will have the same level of competency in all items. Each person has many levels of skills at any point in time. When an individual encounters new situations, competence is affected by the demands of the situation. If you have changed jobs, type of settings, type of populations served, or job roles in the past year, your level of competence may be different than if you rated yourself in the previous situation. Each situation brings new job demands that require defined competencies to meet the job demands effectively.

Feedback from a supervisor or colleague may be helpful in rating the items. Another effective way to use the Self-Appraisal Competency Checklist is to schedule time with a peer or a mentor to help you organize the process and complete the forms, and to assist with setting goals. Working with another person can help you to stay focused and motivated in the process. It does take time to complete the charts, and you will probably need to work on them during several different times.

The checklists are designed to assist practitioners in assessing practice competence and in structuring a professional development plan to maintain and update practice skills.

Managerial competence is not included on the checklists because they are not intended to be used to assess administrative skills. They are designed to be applicable for both registered occupational therapists and certified occupational therapy assistants, as noted. They may be used in all settings, with all populations, and for all levels of experience. They may be used as supervisory tools to assist in establishing ongoing competency and in setting yearly goals. It is recommended that these tools be used at least yearly for an overall assessment or a "focused" assessment of professional competency. If changes occur in job demands or roles, it may be helpful to use them to determine which skills need to be updated in order to perform effectively in the new job situation. They may also be used for periodical review to determine the progress in updating and maintaining skills in this new role or job demand.

Chart I - Practitioner Competency - Assessment and Intervention Checklist

On Chart I (Practitioner Competency Items - Assessment and Intervention) you rate yourself on your ability to assess and intervene in the performance areas, components, and contexts listed in the left-hand column. Refer to *Uniform Terminology--Third Edition* (AOTA, 1994d) for definitions of the terms. Space has been provided for you to list the assessments and interventions used in your particular practice setting or with a particular type of impairment.

After you have determined the assessments and interventions to be appraised, the competency rating scale of *Not Proficient*, *Basic*, *Intermediate*, and *Advanced* needs to be applied. The following are definitions of these terms:

Not Proficient	No or inconsistent competency and unable to effectively demonstrate knowledge and skill.
Basic	General proficiency in familiar performance contexts.
Intermediate	General proficiency and able to adapt and generalize knowledge and skill in familiar and unfamiliar performance contexts.
Advanced	Expert proficiency and able to creatively integrate knowledge and skill in familiar and unfamiliar performance contexts.

In deciding the areas to be increased or updated, the following factors need to be considered:

Maintaining some skills can occur by continuing to perform the skill on a regular basis. To determine if a skill needs to be increased, you will also need to evaluate whether your current setting, population served, or job demands the skill to be at a certain level. It may be necessary to continually update some skills due to new research, materials, or theory development. In order to remain current, activities to update knowledge and skill may need to be completed. Updating may also need to be done if a particular skill has not been performed on a regular basis. For example, a skill in which you had advanced competency may drop to an intermediate level if not used regularly. Checking an item as being at a basic

skill level does not automatically mean you need to update or increase the skill. Basic skill level may be very effective in a particular job situation. Similarly, checking advanced skill level does not mean that you do not need to update the item. New developments and strong personal desire may indicate that an item with advanced skill level still needs to be updated. You may also want to select items to update based solely on your own personal decisions and interest in professional growth.

Chart II - Practitioner Competency Checklist

On Chart II you rate yourself on your ability to perform skills that relate to all areas of practice. The rating scale changes to *Infrequently (less than 50%)*, *Frequently (51-94%)*, and *Consistently (95-100%)*. The left-hand column identifies those skills that are applicable to COTAs and OTRs. You will check items in the right-hand column in which you need to become more competent in order to perform your job duties effectively.

Chart III - Work and Behavior Competency Checklist

All of the items listed on this chart are applicable to both OTRs and COTAs and pertain to work behaviors and not specific therapy competency. The rating scale is the same as was used in Chart II. Those items in which you need to become more competent are checked in the far right-hand column.

Chart IV - Maintaining and Updating Clinical Competency Checklist

This chart is similar to the two previous charts in format. These items pertain to actions and methods that promote professional development and competency. All of the items are applicable to both OTRs and COTAs.

Chart V - Professional Development Plan

Specific directions are given in the section with the Professional Development Plan.

Name_____
Date_____
Job Title_____
Practice Setting Type(s)_____
Impairment or Disability Type(s)_____

CHART I - PRACTITIONER COMPETENCY - ASSESSMENT AND INTERVENTION CHECKLIST

In this section, rate yourself on your ability to assess and intervene in the performance areas, components, and context. Refer to the *Uniform Terminology for Occupational Therapy-Third Edition* (1994d) for definitions of terms. Space has been provided for you to list the assessments and interventions used in your particular practice setting or with a particular type of impairment. The definitions for the rating scale are located in the instructions. **NOTE:** All of the items are applicable for both OTRs and COTAs in accordance with the key performance areas as identified in the *Occupational Therapy Roles* document (AOTA, 1993). Refer to the *Roles* and *Supervision* (AOTA, 1994a) documents to clarify roles and responsibilities.

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
I. **PERFORMANCE AREAS**							
A. Activities of Daily Living (grooming, oral hygiene, bathing/showering, toilet hygiene, personal device care, dressing, feeding and eating, medication routine, health maintenance, socialization, functional communication, functional mobility, community mobility, emergency response, sexual expression)							
Assessments:							
Interventions:							

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
B. Work and Productive Activities (home management, care of others, educational activities, vocational activities)							
Assessments:							
Interventions:							
C. Play or Leisure Activities (play or leisure exploration, play or leisure performance)							
Assessments:							
Interventions:							

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
II. PERFORMANCE COMPONENTS							
A. Sensorimotor Component							
1. Sensory (sensory awareness, sensory processing, perceptual processing)							
Assessments:							
Interventions:							
2. Neuromusculoskeletal (reflex, range of motion, muscle tone, strength, endurance, postural control, postural alignment, soft tissue integrity)							
Assessments:							

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
Interventions:							
3. Motor (gross coordination, crossing the midline, laterality, bilateral integration, motor control, praxis, fine coordination/dexterity, visual-motor integration, oral-motor control)							
Assessments:							
Interventions:							

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
B. Cognitive Integration and Cognitive Components 1. Level of Arousal 2. Orientation 3. Recognition 4. Attention Span 5. Initiation of Activity 6. Termination of Activity 7. Memory 8. Sequencing 9. Categorization 10. Concept Formation 11. Spatial Operations 12. Problem Solving 13. Learning 14. Generalization							
Assessments:							
Interventions:							

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
C. Psychosocial Skills and Psychological Components							
1. Psychological (values, interests, self-concept)							
Assessments:							
Interventions:							
2. Social (role performance, social conduct, interpersonal skills, self-expression)							
Assessments:							
Interventions: 33							

34

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
3. Self-Management (coping skills, time management, self-control)							
Assessments:							
Interventions:							
III. PERFORMANCE CONTEXTS							
A. Temporal Aspects 1. Chronological 2. Developmental 3. Life Cycle 4. Disability Status							

35

36

Practitioner Competency Items	Not Proficient	Basic	Inter-mediate	Advanced	Need to Increase	Need to Update	Comments
Assessments:							
Interventions:							
B. Environment 1. Physical 2. Social 3. Cultural							
Assessments:							
Interventions:							

37

38

CHART II - PRACTITIONER COMPETENCY CHECKLIST

Note change in rating scale. Infrequently (less than 50%); Frequently (51-94%); Consistently (95-100%)

Applicable to OTRs	Applicable to COTAs*	Practitioner Competency Items	In-frequently	Frequently	Con-sistently	Comments	Need to Increase
X	X	Consider age and developmental level; gender; education; cultural background; and socioeconomic, medical, and functional status when providing OT services.					
X		Select assessments to determine the individual's functional abilities and problems as related to occupational performance areas; occupational performance components; physical, social, and cultural environments; performance safety; and prevention of dysfunction.					
X	X	Administer standardized tests according to defined protocol.					
X	X	Administer criterion-referenced tests according to defined protocol.					
X	X	Use skilled observations, interview, record review, and unstructured tests.					
X		Administer specialized evaluations according to defined protocol.					
X	X	Interpret occupational therapy assessment data.					
X	**	Analyze and summarize collected evaluation data to indicate the individual's current functional status.					
X	X	Assess and incorporate effect of the environment/context of performance in patient care.					
X	**	Estimate potential for response to OT intervention.					
X	**	Develop goals and recommendations based on assessment results that are clear, measurable, behavioral, functional, and appropriate to the individual's needs, personal goals, and expected outcomes after intervention.					
X	**	Establish goals in collaboration with individual.					
X	**	Update goals as performance changes.					
X	**	Establish measurement methods for determining achievement of goals.					
X	**	Determine the frequency and duration of occupational therapy services.					
X	**	Refer individuals to other appropriate resources when the therapist determines that the knowledge and expertise of other professionals is indicated.					

*Under supervision of OTR **Contributes to the process in collaboration with an OTR

39 40

CHART III - WORK AND BEHAVIOR COMPETENCY CHECKLIST

All of the items apply to both OTRs and COTAs.

Maintaining and Updating Clinical Competency Items	In-frequently	Frequently	Con-sistently	Comments	Need to Increase
State functional outcome in documentation that is meaningful and appropriate to individual patient/client.					
Document clearly, timely, and meet facility policies and procedures and applicable regulations.					
Use time efficiently and do job tasks in a reasonable amount of time.					
Handle multiple work demands and variable schedules and caseloads.					
Monitor own performance and identify supervisory needs.					
Actively participate and responsibly respond in the supervisory relationship.					
Accommodate to change and modify own behavior according to the demands of the situation.					
Accommodate personal style to work effectively with a variety of people.					
Accommodate priorities according to the needs of the program, department, and others.					
Actively contribute information in meetings, conferences, and informal interactions.					
Appraise and communicate the value of occupational therapy to a variety of audiences.					
Identify consultation needs and effectively negotiate with appropriate sources to receive needed consultation.					
Function according to the AOTA *Code of Ethics* (1994b) and *Standards of Practice* (AOTA, 1994c) of the profession.					
Comply with the institution's protocols, policies, and procedures.					
Demonstrate an understanding of the financial implications of treatment costs and resources on occupational therapy services.					
Synthesize and analyze the information from federal, state, and local laws that has a direct impact on the delivery of occupational therapy services.					
Participate in quality improvement activities.					

CHART IV - MAINTAINING AND UPDATING CLINICAL COMPETENCY CHECKLIST

All of the items apply to both OTRs and COTAs. Space is provided at the bottom to add items specific to your situation.

Maintaining and Updating Clinical Competency Items	In-frequently	Frequently	Con-sistently	Comments	Need to Increase
Identify and pursue own professional growth and development.					
Seek out new knowledge.					
Actively pursue learning.					
Check own clinical reasoning and decision making.					
Double check interventions with other OT practitioners and health care providers.					
Critically examine own practice and integrates new knowledge.					
Maintain and use network to remain current and validate practice.					
Identify consultation as a method to maintain and update clinical competence.					
Use a variety of methods to maintain and update clinical skills and competence. (Peer review, chart audit, video, observation of case studies, literature review, continuing education.)					
Maintain current knowledge of the legislative, political, regulatory, social, and cultural issues that affect the profession.					
Seek out knowledge about research relevant to areas of practice.					
Apply research to practice.					
Share knowledge and actively participate in the professional development of others.					
Provide inservice education to facility and the community.					
Provide consultation to practitioners and outside groups.					
Participate in professional and community activities.					

Chart V - Professional Development Plan

This process is designed to assist in creating a Professional Development Plan to ensure continued competency. Use Chart V and follow the steps to develop an individualized plan.

1. Area to Increase or Update

Review Charts I, II, III, and IV to determine the items you need and desire to increase or update. In selecting the items to increase or update, you may want to first determine the skills you need to have in order to perform in your current job and role. Second, you might select those that are purely for your own professional growth. Asking a colleague or supervisor to review this section with you may provide you with additional information for your professional development plan.

2. Goals

Write measurable and objective goals for each area.

3. Methods to Achieve Competency

After you select the items, determine the best methods to increase or update your competence. Remember that it is desirable to use several methods in your total Professional Development Plan in order to minimize the limitations inherent in each method. Additional spaces have been provided to customize your plan.

4. Target Date

Finally, set a targeted completion date for each item. Try to be realistic in regard to your time and the resources available to you. Remember, this is intended to be a tool to help you.

5. Date Developed, Reviewed, and Completed

Record date the plan was established. Plan to review it regularly. Record the dates you review it and when areas are completed.

NOTE: See Appendix for vignettes demonstrating how the self-appraisal tool may be used.

CHART V - PROFESSIONAL DEVELOPMENT PLAN

Date Developed_____
Date Reviewed _____

Area to Increase or Update	Goals	Methods to Achieve Competency: Independent Study	Academic Coursework	Continuing Education	Teaching Activities	Presentations	Publications	Research Activities	Professional Certification	Specialty Certification	Recertification	Preceptor/Supervisor/ Mentor Relationship	Peer Review	On-the-Job Training			Target Date	Date Completed
46																		47

Note: You may need to make additional copies of this chart.

Appendix

Vignettes

Vignette #1

Nancy Nordstrom had 3 years of experience as a COTA, all of which had been in the school system. She was employed by a large agency that provided contract occupational therapy services in a variety of settings. In the school system environment, she worked with daily on-the-job supervision in an OTR/COTA partnership. In conjunction with company management, she decided to rotate to a position at a psychogeriatric unit in a skilled nursing facility. In this facility, supervision by an OTR occurred on a weekly basis.

Nancy decided to conduct a self-appraisal to determine her level of competence in specific performance areas. The first step in the process was to complete Chart I (Practitioner Competency - Assessment and Intervention Checklist). In completing the chart, she determined that two of the areas in which her knowledge and skill needed to be increased from "Not Proficient" to "Basic" were orientation and memory in relation to activities of daily living. She also determined several other areas in which she needed to increase her knowledge and skill levels.

Nancy proceeded to Chart II (Practitioner Competency Checklist) and determined that she had no experience administering some of the standardized evaluations for the patients with whom she would be working in this new practice setting. She wanted to acquire basic knowledge in this area and be able to work collaboratively with the OTR who was supervising her. When Nancy completed Chart III (Work and Behavior Competency Checklist) and Chart IV (Maintaining and Updating Clinical Competency Checklist), she determined that she frequently performed all items on these checklists.

The next step was to complete the professional development plan. This was done in collaboration with her supervisor. Together they concluded that Nancy would pursue the following activities to increase her competency: 1) participate in continuing education activities (i.e., AOTA self-study series and attending courses and inservices); 2) participate in independent study, including reviewing relevant occupational therapy literature (textbook and journal articles); and 3) develop a preceptor relationship with her supervisor. Timelines were established to review her progress, and an estimated target date for completion was set.

Vignette #2

Sam F. Cisko is an OTR who has practiced in pediatrics for 6 years. He just received an excellent performance review for a staff-level therapist. Sam's 3- to 5-year goal was to be promoted to a clinical specialist position at his facility. In order to do this, he needed to increase his overall skill level from intermediate to advanced. A long-term goal was to present workshops on pediatric assessments. After completing the self-appraisal tool, Sam identified that he needed advanced knowledge in the area of sensorimotor components. He rated himself with an intermediate skill level in performing several assessments, but identified the need for more advanced knowledge in interpreting the results. In addition, he had no experience with several of the newly developed assessment tools. After completing the professional development plan, Sam decided that the most appropriate methods to become a clinical specialist were to 1) enroll in a graduate course in pediatric assessments offered by the occupational therapy program at the local university; 2) attend continuing education courses on new assessment tools; 3) participate in a local study group; and 4) complete on-the-job training with a therapist who has completed the pediatric specialty certification process.

After increasing and updating his knowledge and skills, Sam planned to actively pursue the pediatric specialty certification. In the future he would also seek out opportunities to do presentations in his area of specialization.

Vignette #3

Pam H. Pack is an OTR with 15 years of clinical experience. After 5 years of managing a department, she returned to work in a private hand therapy practice. After using the self-appraisal chart to assess her current level of knowledge and performance skills, Pam determined that in the area of neuromuscular intervention, she needed to increase and update her knowledge and skills in the use of physical agent modalities as an adjunct to purposeful activity.

When completing the professional development plan, Pam decided that the most appropriate methods to achieve competency would be to 1) attend a continuing education course on physical agent modalities that included both didactic instruction (knowledge) and experiential learning with the modalities (performance), 2) receive on-the-job training in the use of specific modalities, 3) enter into a preceptor relationship with a colleague who is skilled and knowledgeable in regard to physical agent modalities, and 4) include peer review in the use of physical agent modalities as part of her annual performance review process. Timelines were established with estimated target dates for completion.

References

American Occupational Therapy Association. (1993). Occupational therapy roles. American Journal of Occupational Therapy, 47, 1087-1099.

American Occupational Therapy Association. (1994a). Guide for supervision of occupational therapy personnel. American Journal of Occupational Therapy, 48, 1045-1046.

American Occupational Therapy Association (1994b). Occupational therapy code of ethics. American Journal of Occupational Therapy, 48, 1037-1038.

American Occupational Therapy Association (1994c). Standards of practice for occupational therapy. American Journal of Occupational Therapy, 48, 1039-1043.

American Occupational Therapy Association (1994d). Uniform terminology for occupational therapy - third edition. American Journal of Occupational Therapy, 48, 1047-1054.

American Occupational Therapy Certification Board. (1991). AOTCB and state regulation: A partnership to protect the public (pamphlet). Rockville, MD: Author.

Bailey, D., Buysse, V, & Palsha, S. (1990). Self-ratings of professional knowledge and skills in early intervention. Journal of Special Education, 23, 423-435.

Carline, J., Wenrich, M., & Ramsey, P. (1989). Characteristics of ratings of physician competence by professional associates. Evaluations in the Health Professions, 12, 409-423.

Cottrell, R. (1990). Perceived competence among occupational therapists in mental health. American Journal of Occupational Therapy, 44, 118-124.

Dubin, S. (1990). Maintaining competence through updating. In S. Willis & S. Dubin (Eds.), Maintaining professional competence (p.23). San Francisco: Jossey-Bass.

Farr, J., & Dubin, S. (1980). Relationship among individual motivators, work environment, and updating in engineers. A final report prepared for National Science Foundation Grant No. SED78-21940. Washington, DC: National Science Foundation.

Gray, M. (1977). Competency assurance applying the concept. American Journal of Occupational Therapy, 31, 580-581.

Guerrero, J., & Hansen, M. (1993). Career ladder program. Journal of Continuing Education and Nursing, 24, 32-36.

Hays, R. (1990). Assessment of general practice consultations: Content validity of a rating scale. Medical Education, 24, 110-116.

Hinojosa, J., & Hansen, R. (1992). Advanced practice review (A report to the Representative Assembly). Rockville, MD: American Occupational Therapy Association.

Humphry, R., & Geissinger, S. (1992). Self-rating as an evaluation tool following continuing professional education. Occupational Therapy Journal of Research, 12, 111-121.

Inman, L., & Haugen, C. (1991). Six criteria to evaluate skill competency documentation. Dimensions of Critical Care Nursing, 10, 238-245.

Kane, M. (1992). The assessment of professional competency. Evaluations and the Health Professions, 15, 163-182.

Kaufman, H. (1990). Management techniques for maintaining a competent professional work force. In S. Willis & S. Dubin (Eds.) Maintaining professional competence (pp. 249-258). San Francisco: Jossey-Bass.

Klemp, G. (1977). Three factors of success. In D. W. Vermilye (Ed.), Relating work and education: Current issues in higher education (pp. 102-109). San Francisco: Jossey-Bass.

Kremer, B. (1991). Physical recertification and outcomes assessment. Evaluation and the Health Professions, 14(2), 187-200.

Mabe, P., & West, S. (1982). Validity of self-evaluation of ability: A review and meta-analysis. Journal of Applied Psychology, 67, 280-296.

Malone Beach, E. (1987, August). Cognitive ability, depression, and performance perception. Paper presented at annual meeting of American Psychological Association, New York.

Mandelbaum, L. (1987). Periodic competency review: An assessment and policy model. Evaluation and the Health Professions, 10, 342-358.

Mays, M. (1986). Assessing the range of practice by physical therapists after a continuing education program. Physical Therapy, 64, 50-55.

Mir, M., Evans, R., Marshall, R., Newcombe, R., & Hayes, T. (1989). The use of videorecordings of medical postgraduates in improving clinical skills. Medical Education, 23, 276-281.

Page, G., VanWart, A., Raudzus, D., & Kettyls, G. (1979). The effect of continuing medical education programs on clinical practice: Fact or fantasy. Medical Education, 13, 292-297.

Phillips, I. (1991). What is competency and can it be assured? San Antonio, TX: National Organization for Competency Assurance.

Poole, J. (1989). Occupational therapist's self-assessment after participation in a course on theory and research. Occupational Therapy Journal of Research, 9(2), 114-123.

Pottinger, P. (1979). Competence assessment: Comments on current practices. In P. S. Pottinger & J. Goldsmith (Eds.), Defining and measuring competence (pp. 25-39). San Francisco: Jossey-Bass.

Richert, A. (1988). Teaching teachers to reflect: A consideration of program structure (Unpublished manuscript). Mills College, Oakland, CA.

Saylor, C. (1990). Reflection and professional education: Art, science, and competency. Nurse Educator, 15(2), 8-11.

Weerakoon, P., & Fernando, D. (1991). Self-evaluation of skills as a method of assessing learning needs for continuing education. Medical Teacher, 13(1), 103-106.

Willis, S., & Dubin, S. (1990a). Approaches to specifying, measuring, and assessing professional competence. In S. Willis & S. Dubin (Eds.) Maintaining professional competence (pp. 85-94). San Francisco: Jossey-Bass.

Willis, S., & Dubin, S. (1990b). Competence versus obsolescence: Understanding the challenge facing today's professionals. In S. Willis & S. Dubin (Eds.), Maintaining professional competence (pp. 1-5). San Francisco: Jossey-Bass.

Willis, S., & Tosti-Vasey, J. (1990). How adult development, intelligence, and motivation affect competence. In S. Willis & S. Dubin (Eds.), Maintaining professional competence (pp. 64-83). San Francisco: Jossey-Bass.

Wilson, M. (1977). A competency assurance program. American Journal of Occupational Therapy, 31, 573-579.

Bibliography

American Occupational Therapy Association (1980). Training: Occupational therapy educational management in schools, Volumes 1-4. Rockville, MD: Author.

American Occupational Therapy Association (1983). AOTA fieldwork evaluation form for occupational therapy assistant students. In Reference manual of the official documents of The American Occupational Therapy Association, Inc. (Fifth edition) (pp.11.33-11.48). Rockville, MD: Author.

American Occupational Therapy Association. (1987). The American Occupational Therapy Association, Inc. fieldwork evaluation for the occupational therapist. In Reference manual of the official documents of The American Occupational Therapy Association, Inc. (Fifth edition) (pp.11.25-11.32). Rockville, MD: Author.

American Occupational Therapy Association (1990). Entry-level role delineation for registered occupational therapists (OTRs) and certified occupational therapy assistants (COTAs). American Journal of Occupational Therapy, 44, 1091-1102.

American Occupational Therapy Association (1994). Policy 3.11 Competency. In Policy Manual of The American Occupational Therapy Association, Inc. Rockville, MD: Author.

American Occupational Therapy Certification Board. (1992). Disciplinary action: A process to protect the public (pamphlet). Rockville, MD: Author.

Duke, D. L., & Stiggins, R. J. (1986). Teacher evaluation, five keys to growth. Washington, DC: American Association of School Administrators.

Hunter, M. (1988). Create rather than await your fate in teacher education. In S. J. Stanley & W. J. Poplan (Eds.), Teacher evaluation, six prescriptions for success (pp.32-54). Ann Arbor, MI: Edwards Bros.

Idol, L., Paolucci-Whitcomb, P., & Nevin, A. (1986). Collaborative consultation. Austin, TX: Pro-ED.

Jaffe, E., & Epstein, C. (1992). Occupational therapy consultation: Theory, principles, and practice. St. Louis, MO: Mosby.

Millman, J. (1981). Introduction. In J. Millman (Ed.) Handbook of teacher evaluation (pp. 12-13). Beverly Hills, CA: Sage.

Norman, G., Neufeld, U., Walsh, A., Woodward, C., & McConvey, G. (1985). Measuring physicians' performances by using simulated patients. Journal of Medical Education, 60, 925-934.

Weigan, J. (1977). Implementing teacher competencies. Englewood Cliffs, NJ: Prentice Hall.

Woodward, C., McConvey, G., Neufeld, U., Norman, G., & Walsh, A. (1985). Measurement of physicians' performance by standardized patients: Refining techniques for undetected entry in physicians' offices. Medical Care, 23, 1019-1027.

Authors:

The Competency Task Force:
Linda Kohlman Thomson, MOT, OTR, OT(C), FAOTA - Chairperson
Deborah Lieberman, MHSA, OTR/L, FAOTA
Roberta Murphy, BPA, COTA, ROH
Eugene Wendt, PhD, OTR
Janet Poole, MA, OTR, FAOTA
Sarah D. Hertfelder, MEd, MOT, OTR - Staff Liaison

for

The Commission on Practice
Jim Hinojosa, PhD, OTR, FAOTA - Chairperson

AOTA The American Occupational Therapy Association, Inc.

The American Occupational Therapy Asssociation, Inc.

4720 Montgomery Lane, P.O. Box 31220
Bethesda, MD 20824-1220
301-652-AOTA (2682)
301-652-7711 Fax
800-377-8555 TDD